CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

August 27, 1999

S. 406
Alaska Native and American Indian Direct Reimbursement Act of 1999

As ordered reported by the Senate Committee on Indian Affairs on August 4, 1999

SUMMARY

S. 406 would extend indefinitely an Indian Health Services (IHS) demonstration project that allows four tribally-operated IHS facilities to bill the Medicare and Medicaid programs directly, rather than submitting their claims through the IHS. The bill also would allow all other tribally-operated IHS facilities to bill Medicare and Medicaid directly. CBO estimates that the bill would raise federal outlays by $9 to $10 million in each of fiscal years 2001 to 2004. Federal Medicare outlays would be higher by about $3 million a year, and federal Medicaid outlays would be higher by about $7 million a year. Because the bill would affect direct spending, pay-as-you-go procedures would apply.

S. 406 contains no private-sector or intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). Participation in the direct billing program could improve the cash-flow of health facilities operated by tribal governments.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 406 is shown in the following table. The costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

	Outlays, By Fiscal Year, in Millions of Dollars					
	1999	2000	2001	2002	2003	2004
CHANGES IN DIRECT SPENDING						
Medicare	0	0	3	3	3	3
Medicaid	0	0	7	7	6	6
Total	0	0	10	9	9	9

Note: Components may not sum to totals because of rounding.

BASIS OF ESTIMATE

Under current law, four tribally-operated Indian Health Service demonstration sites are authorized to bill the Medicare and Medicaid programs directly rather than submitting their claims through the IHS. The demonstration authority expires September 30, 2000. S. 406 would allow all tribally-operated IHS facilities to bill Medicare and Medicaid directly.

According to IHS, seven hospitals are tribally-operated and would likely choose to bill Medicare and Medicaid directly. In 1997, Medicare and Medicaid collections totaled $55 million in these facilities. In addition, more than 150 health stations, health centers, and clinics would be eligible to bill directly under the legislation. CBO assumes that all of the hospitals would choose to bill directly over the next several years but that only a few of the largest of the other facilities would develop the infrastructure necessary to adopt direct billing. CBO further assumes that a few additional hospitals would become tribally-operated and begin to bill directly.

Based on information from the IHS on the experiences in the demonstration sites, CBO assumes that direct billing would increase Medicare and Medicaid payments for two reasons. First, the demonstration sites report a reduction in the amount of time between filing reimbursement claims and receiving payment. CBO therefore assumes that in the first year a facility participated in direct billing, it would receive one to two extra months worth of Medicare and Medicaid payments. The legislation would also increase federal costs in the four existing demonstration sites because under current law they are required to return to billing Medicare and Medicaid through IHS and will therefore experience a one- to two-month slow-down in Medicare and Medicaid collections. Of the $37 million in estimated Medicare and Medicaid costs over the 2000-2004 period, $11 million is attributable to the one-time acceleration of payments.

Second, demonstration sites reported increased Medicare and Medicaid payments under direct billing because of improved claims processing. The sites reported that they were better able to track their claims and to correct errors under direct billing than when they filed their claims through the IHS. Medicare and Medicaid payments have grown dramatically in both demonstration sites and nondemonstration IHS facilities in the ten years since the demonstration was authorized. Much of the growth stems from higher Medicare and Medicaid reimbursement rates for IHS facilities, efforts by IHS to improve its Medicare and Medicaid collections, and general growth in medical costs and enrollment, rather than from direct billing. Nonetheless, based on the experience in the demonstration sites, CBO assumes that the improved claims processing procedures that direct billing enables would increase Medicare and Medicaid payments by about 10 percent in the facilities that choose to undertake it.

In addition, direct billing may slightly reduce IHS administrative costs, which are subject to annual appropriations.

PAY-AS-YOU-GO CONSIDERATIONS

Section 252 of the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars										
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Changes in outlays	0	0	10	9	9	9	9	10	11	11	12
Changes in receipts	Not applicable										

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

S. 406 contains no intergovernmental mandates as defined in UMRA. By allowing all tribally-operated IHS facilities to bill Medicare and Medicaid directly, the bill would shorten the period of time for receiving reimbursements and improve processing procedures.

Medicare and Medicaid amounts supporting trial health facilities are 100-percent federally funded. The direct billing would increase the cash-flow position of facilities that chose to participate.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains no private-sector mandates as defined in UMRA.

PREVIOUS CBO ESTIMATES

In July 1998, in a letter to Senator Frank H. Murkowski, CBO estimated that extending the direct billing authority would increase Medicare and Medicaid costs by about $5 million a year. CBO relied on a similar methodology in this estimate, but the estimate now is higher for two reasons. First, in January 1999 the Department of Health and Human Services increased the rates paid to IHS facilities by an estimated 15 percent. The higher rates increase the cost of the legislation because there would be larger amounts paid to the facilities that implement direct billing. Second, a very large hospital, Alaska Native Medical Center (ANMC), whose Medicare and Medicaid collections are almost as large as the total for the other tribally-operated hospitals that do not participate in the demonstration project, has become tribally-operated since CBO completed the July 1998 estimate. In the earlier estimate CBO assumed that ANMC would become tribally-operated and participate in direct billing late in the projection period. Now CBO assumes ANMC would participate shortly after the bill becomes effective.

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